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CONNECT2HEALTHFCC TASK FORCE
VIRTUAL LISTENING SESSION - POLICYMAKERS FORUM

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PROCEEDINGS

(1:30 p.m.)

OPERATOR: Ladies and gentlemen, thank you for standing by and welcome to the Connect2Health FCC Virtual Listening Session Policymakers Forum. At this time all participants are in a listen-only mode and later you will have an opportunity to queue up by pressing * then 1. We will also have an interactive session in the call where you will need to mute accordingly as well. If you should require assistance during the call you may press * then 0. As a reminder, this conference is being recorded. Currently we will be taking a role call and I'll provide the names of the callers.

We have Eli Fleet with HIMSS; Jacob Terrell, National Association of Counties; Jennifer Plymale with Marhsall University; Maria Givens with NCAI; Tim Carney with ASTHO; Kamala Hart with FCC; Patty Mechael with HIMSS; Carolyn McCoy with ASTHO; Eric Frederic with Connected Nation; Cindy Muir with NARUC; Andy Rhea with

Cherokee Health Systems; Chantal Worzala with American Hospital Association; Jeff Hallstrand with Price County Teleplant; Tracy Hines with Colorado Telehealth; Michael Morris with WVDHHR; Jeff Reardon with FCC; Michele Ellison with FCC Task Force; Susan Howard with NADO; Tracy Brewer with Ohio University; Angela Panettieri with National League of Cities; Leonie Heyworth with VA; Michael Iaquinta with iSelectMD; Suleima Salgado with Georgia Department of Health; Kevin Galpin with VHA; John Peters with Veterans Affairs; William England with HRSA; Elaine Gardner with FCC Disability Rights Office; Emily Moore with ASTHO; Maureen Lewis with NTIA; Tom Watson with Anderson Court Reporting; Gayle Teicher with FCC; Yahya Shaikh with Connect2Health. We also have on the call Chris Gibbons, David Ahern, Ben Bartolome, and Karen Onyeije. At this time I would like to turn the conference over to our host, Karen Onyeije. Please go ahead.

MS. ONYEIJE: Thank you, Carolyn, we appreciate that. Good afternoon, everybody. My

this virtual listening session is related to the Commission's April 24, 2017 Public Notice on Broadband Health, and it is the fourth in the series. The vision behind these listening sessions is really to create an acceptable mechanism to accommodate the significant interest in this broadband health proceeding from numerous stakeholders across the country.

One of the key areas of focus that we had is on the broadband health gap. By that I'm referring to the apparent divide at the intersection of broadband and health between rural and underserved communities on the one hand and their more urban and digitally connected counterparts on the other. Based on some data analysis conducted by the Task Force we found that, unfortunately, the broadband health divide is wide and it's growing. For example, we found that the picture of health remains vastly different in connected communities than in digitally isolated communities, and that that is true even if you look at access to care, quality

of care, and health outcome metrics.

So, one quick example is if you take 2015 broadband data the least connected counties actually have the highest rates of chronic disease. So, for obesity it's 25 percent higher, for diabetes it's 41 percent higher. In fact, what concerns us is that rural counties are ten times as likely as urban areas to be in low broadband access, and I mean by that below 50 percent, and high diabetes areas, so above the national average, about 10 percent. Unfortunately these digitally isolated counties also experience physician shortages that are more than double the national average.

Just earlier this week a study was released about how cancer rates are declining nationally but that Americans living in rural areas are more likely to die of cancer. What we're clinging to is the hope that we got from stakeholders like the National Cancer Institute and others who believe that connected health can improve detection and treatment of cancers in

rural areas and will be able to address some of this early mortality and morbidity. The sad thing here though is that these cancer hot-spot areas in rural America coincide with low connectivity areas.

So, our charge today is to solicit your perspectives on where we are with this broadband health divide and to get potential solutions from you. We want to gather actionable input on the persistent challenges and transformative opportunities that are posed by broadband and health in rural and underserved areas. And we really want to drill down if we can to concrete ideas for moving the ball forward.

As you've heard, we are a pretty large group on the call today and a very diverse group of participants. There are more than 12 states represented and we're really delighted that you saw value in sharing your views with us. We have representatives from federal and state government, from state and regional health networks, public health departments, academia, different levels of

government as I said, and tribal nations as well. On behalf of Michele Ellison who is our Deputy General Counsel and Chair of the Connect2Health FCC Task Force we just want to thank you again for taking time from your busy schedule to join today's session.

Now, we want to hear from you but I'd like to give my co-moderator, Ben Bartolome, a few minutes to share with you an overview of how we're going to proceed during the roughly one-and-a-half hours that we have together. I will tell you, because this is our third session, that the time will go by very quickly so we want to proceed as efficiently as we can. Ben?

MR. BARTOLOME: Thank you, Karen. As we previously informed you, this session is being recorded and the recording will be transcribed and the transcript once complete will be made publicly available on our website at www.fcc.gov/health. It will also be part of the official record in GN Docket No. 16-46, which is the FCC's Broadband Health Docket.

Prior to this call we sent all of you a copy of the Broadband Health Public Notice and a list of thought questions in order to give you an opportunity to think about what you might want to share in advance of today's session. So we're really looking forward to hearing your input. Among other things, the input we receive from you will be used by the Task Force in making recommendations to the Commission, and your input will also serve to inform us about future projects and initiatives we might pursue. So, it's really important that we hear from as many of you today as possible.

We remind you that if you have any additional comments or input after today's session, especially if something comes to mind later on, we would encourage you to file written comments in the docket and we sent you instructions for how to go about doing that. In addition you may also contact us directly via email at connect2health@fcc.gov. It's the same email address we've been using to in sending you

information for today's session.

Now, in terms of format, we are dividing the session into three segments. Segment one, which will be about 15-20 minutes, will be devoted to grounding the session with information from specific participants that we hope you'll find informative and we think will serve as an appropriate level set for today's session.

In segment two, which will run about 45 minutes, we'll focus on the questions we sent you in advance. Those questions relate to two broad themes that we want to cover today. The first is about potential solutions for bridging the broadband health divide and the second is about emerging issues in broadband health that you think the FCC as well as other policymakers should really be focusing on.

For segment three, we want to reserve roughly about 15 minutes at the end to give anyone an opportunity to provide any other comment or input, even if unrelated to the two themes I just mentioned. Finally, if there is time remaining --

but I'm anticipating not because we have a pretty large group which is fantastic by the way; but if there is time remaining, we may also open up the lines for more free-flowing discussion.

Now, when you are speaking for the first time please feel free to tell us a little bit about yourself and your organization, and also please tell us which city and state you're calling from. Again, as a reminder, as our AT&T Operator Carolyn instructed, whenever you're ready to provide a comment in response to a question please just press * and then the number 1 on your phone and you'll be put in queue.

I think that's it. Let me now turn the session over to Karen to get us started on the substance. Karen?

MS. ONYEIJE: Thanks, Ben, I appreciate that. As Ben mentioned, this first segment is really designed to give us all a shared starting point for the discussion. We're going to ask a couple of participants to kick things off for us. At this point, can I ask -- I think you guys are

on -- Dr. Patty Mechael, Maureen Lewis, and our colleagues from the Veterans Health Administration, Dr. Kevin Galpin and John Peters, would the four of you please press * and then the number 1 on your touchtone phones just to join the queue now? That would be fantastic.

So, participants, I'm just going to signal that we're going to move very quickly through some of this general information that we're hoping to elicit. It will be about the future of healthcare and connectivity and how consumers are or aren't adopting the internet for health, which obviously will be incredibly relevant to the FCC and other policymakers in the broadband health space. And then also we want to get some sense from the Veterans Health Administration about specific telehealth models, lessons learned, challenges and so forth that can help inform a roadmap for success.

We hope that these comments are going to get your thoughts flowing and we're going to try to keep the segment to 15 minutes, so just note

down any thoughts that you have as we go through this. We will give you an opportunity to respond or echo or amplify what you're hearing from these folks.

All right. So, Carolyn, would you please open the line of Dr. Patty Mechael and announce her please?

DR. MECHAEL: Hi, there. Is my line open?

MS. ONYEIJE: Oh, fantastic, I wasn't sure. Dr. Patty Mechael, thanks again for joining us. We really appreciate it. Can you tell us briefly about the personal connected health alliance and your background? And then we're really hoping that you might be able to offer us and the group some perspectives on the future of healthcare as it relates to broadband connectivity and some of the future realities that you think policymakers like the FCC and others on the call need to be thinking about and preparing for now?

DR. MECHAEL: Sure, thanks, Karen, and

thanks to the FCC for taking this on as an issue and bringing us all together around it. It's incredibly important. My name is Patty Mechael and I run a part of the HIMSS Organization called the Personal Connected Health Alliance. For us personal connected health and the focus of our work is really on helping to make health and wellness an effortless part of daily life through the increased use and strategic use of personal connected health devices.

So, we now know that there are more mobile phones than people on the planet, and so we live in a highly connected world. Through these connections, what we're finding are a number of major trends that are happening in society that are now starting to find their way into the health spectrum.

So, one of the major trends that we are seeing in this space is a movement towards personalization and consumerization of everything. So, travel has become increasingly consumerized, shopping has become increasingly personalized, our

interactions through social media and even the advertising that we are exposed to is increasingly being tailored towards individuals.

We are seeing similar trends in the health sector, and a lot of that is being driven by innovations in technology as well as innovations in science. So, genomics is playing an incredibly important role in moving us towards a more highly personalized experience in health where through the combined use of data from systems and tools like electronic health records to your mobile phone to the data that is coming in through the increased use of wearable technology, and then if you add all of those thing with genomics we're now getting to a more highly personalized approach to health which also is pushing into another trend within health is the shift from treatment of disease and detection of disease into prevention of disease.

Now a lot of the data that we have from a population health perspective is giving us greater insight into where are populations most at

risk where do we need to focus attention in terms of our efforts from a health service perspective, but then where are some of the key opportunities not only to do early detection and treatment but to actually prevent disease in the first place? And this push towards prevention I think is going to be really, really important and is also being driven by a lot of the policy work that a number of you all have been driving forward around value-based care which is really how do we keep people out of the healthcare system in their homes and supported for longer?

One of the other major trends that we're finding in this space is a rapidly aging population in the United States as well as throughout the world. And this desire by boomers to maintain a sense of independence as well as to maintain their mobility, their activity, et cetera, and again the proliferation of personal connected health devices is playing an important role in that. Now, none of these tools are going to be very, very useful if we don't have

connectivity, so broadband is the enabler that facilitates a lot of this.

And then also if you think about and look at even the recent natural disasters that have happened, there is an important role that telehealth and remote patient monitoring is playing on the treatment side. So, when you have shortage of healthcare providers in some of these key geographic locations, then the importance and the role of telehealth, remote patient monitoring and these types of resources and tools, becomes even more important.

So, we're seeing throughout the world, including in the United States and from the research that we're doing that there's like a 20 percent uptick in the use of connected health devices. And we feel that this number is only going to continue to increase, particularly as more and more people get involved in their own self-management of illness, self-care, as well as the intensified drivers around value-based care and really pushing more of the onus on individuals

to become much more involved in taking care of themselves. I think this has huge implications not only for rural areas but also for urban areas, that we need to really look at connectivity in general and what the demands are of the population given the sort of new emerging set of technologies that are coming into the fore and how are the policies and the access to broadband being designed in a way to meet those.

I'll pause right there.

MS. ONYEIJE: Patty, that's fantastic. What I love is that this phrase broadband as enabler, that's great. Can I ask just one quick question of you? You talked about a 20 percent uptake in the use of personal connected devices. I assume you were talking about devices beyond FitBits and the like. Can you give us a sense of what that is?

MS. MECHAEL: Sure. So, for diabetes monitoring we're seeing remote patient monitoring devices and there has been a lot of really great research and evidence in this particular area that

So, NTIA's broadband adoption research indicates that in fact consumers are actively engaged in health related activities online, and the data also suggests that health activities can hold some promise for demonstrating the value of internet connectivity to non-adopters. We revise our survey periodically to reflect the changes in the ways that people access and use the internet.

So, in July 2013 NTIA began asking respondents about online activities such as seeking medical information online, accessing electronic medical records, and connecting to health plans or providers. Then in July 2015 we added another question about health monitoring services that Patty was just talking about.

Because I'm going to be talking a lot of stats I just want to let you know that our complete data sets along with a data explore tool that gives you an opportunity to look at some of this data by demographics and blogs and reports analyzing the data are all available on NTIA's website at www.ntia.doc.gov under our broadband

adoption research. So, I'm going to give you some highlights from our 2013 and 2015 data that are pertinent to our discussion today.

Internet use at any location by individuals ages 15 and older increased from 74 percent in 2013 to 76 percent in 2015. In 2013, percent of internet users, 15 years or older, researched health information online; just two years later in 2015 that percentage had increased almost five-fold to 48 percent according to our data. Between 2013 and 2015 the percentage of individuals 15 or older that accessed health records, insurance information, or communicated with a doctor online grew 20 percentage points from 6 percent to 26 percent. In 2015, which is the first year we began asking about online health monitoring services among internet users ages 15 or older, 6 percent used such services.

But we also have to be greatly concerned with non- adopters. So, according to NTIA's 2015 data, 33 million households, or about 27 percent of all U.S. households, did not use the internet

at home where we know that families can more easily share internet access and conduct sensitive online transactions privately. Of that 33 million, 26 million households which represented a fifth of the nation's households lacked a single member who used the internet at home or at any other location.

Consistently our survey results between 2001 and 2015 reveal a consistent pattern of the reasons why households say they don't use the internet at home and number one has always been they don't perceive a need or don't have an interest in using home internet. The second reason according to these trends said service is too expensive, and the third less frequently cited reason is that these households don't have a computer or the one that they have is not adequate.

So, between 2013 and 2015 we found that the proportion of households that cited no need or interest as their main reason for not using the internet at home increased percentage points from

percent to 55 percent. But the other two reasons actually declined, so those expressing cost concerns or lack of a serviceable computer dropped during that period. Interestingly, these trends were the same regardless of demographics, rural or urban residence, or the presence of school-aged children in the household, although the extent of the changes varied a little bit.

Of the 55 percent of households without home internet use that stated a lack of interest or need for the service in our 2015 survey, 60 percent of these households reported they did not need a service while the remaining 40 percent expressed just general disinterest in having the service at home. But we think that these more detailed reasons for no-home internet use can help inform the development of policies and programs that address these households' concerns.

So, for example, perhaps digital literacy programs introduce non-users to online learning tools on topics that interest them and may stimulate their desire to use the internet at

home. For households that perceive no need for the service information about internet applications that enable them to address health, education, or employment needs may persuade them that the convenience and the privacy of home internet access could improve their lives.

So, with that I'll stop. Thank you very much for your interest.

MS. ONYEIJE: Maureen, thank you very much. You've given us a lot to chew on. And you did warn us right up front, so we appreciate it. Just one quick clarification because obviously we are running short on time. Clearly the trends that you mentioned, some of the trends seem to be trending in the wrong direction from certainly a connected care perspective, but you also talked about 26 million households where there was no one in the household that used the internet at home. We were wondering whether that applied to both fixed broadband and internet use as well as mobile.

MS. LEWIS: Yes, well that includes 26

million households that don't use the internet anywhere, so that's neither at home or at any other location. So, the type of internet connectivity doesn't come into play at all for these households.

MS. ONYEIJE: Absolutely. Thank you. It's not like Ben and I don't have 10 additional follow up questions for you, but let's pause for a minute and have Dr. Galpin and John Peters who lead the Veteran's Health Administration's Office of Connected Care quickly join the conversation at this point. Kevin and John, what we are hoping you can do is given what you just heard can you share briefly some of the underground experiences that you have with successful telehealth models, presumably not related to these 26 million people, and what's working, what hasn't worked? What connectivity challenges are you facing in reaching veterans, particularly those that are living in rural areas?

So, Carolyn would you mind announcing our next two participants, Dr. Kevin Galpin and

John Peters?

OPERATOR: Yes. John Peters from the Veterans Health Administration and Dr. Kevin Galpin from Veterans Health Affairs Telehealth Services. Your lines are open.

DR. GALPIN: This is Kevin Galpin. I really appreciate being invited to this forum. Let me just make sure everyone hears me. Can someone validate I am --

MS. ONYEIJE: We're hearing you perfectly, Kevin. Thank you.

MR. BARTOLOME: Yes, perfectly. Thank you.

DR. GALPIN: Great. I'll go ahead and just give you an overview of who we are and what we do. Me, personally, I'm Kevin Galpin, the Director of Telemedicine for the VA. I have a background in internal medicine in clinical and traumatics and have worked in primary care inpatient medicine health and traumatics and telehealth for the Veterans Administration.

We do a tremendous amount of telehealth.

We find the argument for doing telehealth incredibly compelling as far as our ability to make care more accessible, bringing that appointment out to a rural community, increasing capacity in the organization, moving clinical resources around so we can put providers in areas where they otherwise aren't currently living. And then improving quality; doing some remote type monitoring programs either into the home or in the ICU. So it's really integrated into how we are operating in the organization.

Just to give you some of the scope on this, last year we did 2.17 million episodes of care to 900 VA sites; 45 percent of the veterans that got care from telehealth lived in a rural area. We served over 700,000 veterans in 50 specialty areas.

We do different types of telehealth programs. We do video telehealth, it's called our Clinical Video Program. We've had a long-running success with certainly mental health. Anything that doesn't require a physical examination is

pretty straightforward. When I say physical examination, I should say a hands-on physical examination because through telehealth you are doing an examination, but just not a hands-on one. So, lots of success with mental health, but really it's hard with 50 specialties. I would just say broadly if you don't regard physical examination you can pretty much do your comprehensive clinical assessment through telehealth.

We've also demonstrated some success with even a primary care model where we have providers on the other side of the counter helping to hold stethoscopes, nodescopes (phonetic). We are moving that type of program out. We do video, we do store and forward type applications programs where you might take an image of a dermatologic rash or the back of an eye in a rural location and have someone look at it, a provider look at it, and then send comments back. And we do a lot of remote monitoring, so we have veterans in their home and they're giving us information on a daily basis either signs or symptoms or responses to

questionnaires so we can monitor how they're doing with their care in their home.

I think this is really applicable to the conversation, we have mobile medical units and mobile vet centers and so we have trucks that will go out into the community and will park in certain areas and try and serve communities that are traditionally underserved, any place we're looking at a physical building but don't yet have one. In this type of case broadband becomes a big issue because trying to set up the connectivity for these trucks is challenging. And we've seen how important these types of units are in disaster response, certainly over the past month; and the value that a telehealth response can potentially bring to an emergency area if you have the technology, if you have the connectivity.

But it would be wonderful to know that wherever we go in the country that we would be able to stop a truck, be able to get connectivity, take care of patients. That is something that clearly we're not close to.

I think some of the data that I think people are interested in, and we've talked about the number of encounters, but some of the trends. Just this past year -- and this is part of our major initiative to make care more accessible -- we really want to do more and more of health care in the home. We've formally announced our Anywhere to Anywhere Telehealth Initiative in the VA. We really believe that if the veteran wants their care in the home, on their mobile device, while they're travelling, we should be able to provide that care.

Our data is supporting that. Through August of this year we did over 55,000 encounters to either home or non-VA locations and that is a

percent increase from the year before. We're projecting that we may actually see over the next year, and almost certainly over the next two years, but even next year a 2,000 percent increase over where we are right now. So we think that area of growth is going to be tremendous. We think that there are multiple different types of

specialties where patients are going to prefer getting that type of care at a location of their convenience, either in the home, on a mobile device, while they're travelling, et cetera.

We've seen success with this. There are some nice published research studies coming out of the VA related to PTSD and the non-inferiority of treatment of PTSD into the home versus traditional care. I think we've had two over the past couple of years.

We've also seen cost reduction data and travel reduction data. One study showed that we saved about $28 per episode of telehealth care at a rural site. And we do pay for veterans' travel in a lot of cases so that's different than private sector. But it was over two hours of drive time for the veteran that was saved for each one of these visits. So, at least in our model there is a very strong return on investment type data that you can see. But from a clinical perspective I think there is mounting evidence that this is a successful way to deliver care.

Why this initiative, I think this is so important for us is we have data we've asked our Rural Health Department to produce data about how many veterans -- if we say VA is going to deliver telehealth and care anywhere to anywhere and we're going to push out care into the homes, how many veterans right now can't receive it? That's a critical number for us. When we got our data back, we have about 80- to 90,000 veterans that live in areas where there's either no broadband or no 4G connectivity. These are data based on 2014 so it's not quite just yesterday but that's a big number that we'd like to bring down.

We believe this should be available everywhere. We'd like our programs to be available everywhere. And this is something where we're looking to other organizations, other departments in the federal government to help us with and say how do we reach those veterans? And we certainly have some contingency plans, but again that's a big important number for us.

To summarize, we do lots of different

kinds of telehealth and we really want to do more and more into the home. We think that is, again, where we're going to see tremendous -- and again, the number we're looking at is 2,000 percent growth maybe even just over a one-year period. But we have concerns that we can't reach everyone. And we have by zip codes the number of veterans we can't reach right now and that's our big concern.

MS. ONYEIJE: Kevin, I have to tell you just these stats alone are pretty compelling, both in terms of what successes you've seen and some of the various models. But that 80- to 90,000 number is a little bit chilling especially since you told us earlier on that you did 700,000 episodes of telehealth. You served 700,000 veterans and we're talking over 10 percent of that patient population. So, I want to thank you for putting that out there.

Now, here's what we'd like to do. Obviously Patty and Kevin and Maureen and John, we want you to remain part of this dialogue but what we'd like to do is to go ahead at this point and

move to the second segment where we invite all of the participants to, again, either comment on or echo some of the things that they've heard from the three of you.

Just to get us started, I'd like to just remind you about the couple of themes that we'd like to put on the table for this segment. There are two broad themes and they're certainly consistent with the material that we've shared with you, there are no surprises here. The first, because we as a Task Force are focused on not only defining the problem but making progress towards solving it, so the first theme is solutions for bridging the broadband health divide. And the second is to think a little bit more about some of the issues that Patty put on the table in terms of emerging issues for policymakers in broadband health.

We're going to start with the first issue and we will reserve -- we'll make sure that we get to the second. So, if you want to comment on any of those I would urge you to press * and

then 1 on your touchtone phone and you will be in queue and we will recognize you.

As folks are queueing up here I did want to say in terms of solutions in reaching critical need areas we as a Task Force have been hearing from various stakeholders particularly in rural communities that while they can see the vast potential of broadband in health along the lines of what Dr. Galpin was saying, they're struggling a bit sometimes to operationalize that vision, and they tell us that part of the problem is that broadband health solutions are not getting to the areas and communities that need it the most.

So, here's the question we want to pose to the group: How are states and counties and health departments and tribal nations and other non-profits and philanthropy identifying the specific gap areas, the areas with the most critical need at the intersection of broadband and health? How are we identifying those? And then related to that, do states and local communities have specific broadband health plans, strategies,

policies, for addressing these gap areas, the ones with high health need and low broadband access and adoption. So, I put that out on the table, thank you.

If you would press * then 1 on your phone we will recognize you. Carolyn, would you announce the first participant?

OPERATOR: Yes, absolutely. We did have five more folks join the call. Did you want me to go ahead and announce those names over the call?

MS. ONYEIJE: Yes, that would be great. Thank you.

OPERATOR: Sure. We have Preston Wise from the Wireline Competition Bureau, Eli Fleet from HIMSS, Dr. Kelly Murphy from FCC, Fred Eastman from Mercy Health Network, and Kevin Loux from SOAR.

The response now comes from Chantal Worzala from the American Hospital Association. Please go ahead.

MS. ONYEIJE: Hi, Chantal.

MS. WORZALA: Hi, good afternoon. Thank

you so much for having this call and for all of the work that you are doing on helping to close that broadband health divide. Very exciting work.

I did want to give you a little bit of a sense of how hospitals are using broadband and telehealth. We are at a point where this is becoming mainstream and we have 65 percent of hospitals already using telehealth to some degree and another 13 percent have it on their very short-term plans to implement.

We hear from our members and particularly those in rural areas that lack of adequate broadband is a huge barrier for their ability to deploy telehealth and remote monitoring solutions to address some of the really challenging health divide issues that you've raised in setting up the call.

They do work with their states and local governments but they're also looking to the federal government to help fill in those kinds of blank places on the map. I think the FCC has done a great job in putting together that broadband map

where people can look by zip code and by county to understand where the broadband gaps are, and I know that providers in those communities are really very interested in tapping into some of the resources that the FCC has available. So, I do think that the Rural Health Care Program is crucial, the Healthcare Connect Program is crucial, for filling in those white spaces on the map.

As you know, the AHA did submit comments earlier this year to really encourage some of the improvements in that program that we think will make it a faster road in terms of spreading adequate and reliable broadband. That includes things like increasing the cap, increasing the discount percentage from 65 percent to 85 percent, and really doubling down on administrative simplification for that program.

So, I just want to congratulate you all and thank you all for keeping this issue live. I'll just share that we at the AHA recently had a meeting where we brought 350 leaders from